

Medicaid Billing Requirements for the ADA 1999 v. 2000

Form Locator	Field Name	Medicaid Requirement	Information Requirement
1	Dentist's pre-treatment activities or Dentist's statement of actual activities	Required	Place an "X" in the field marked "Dentist's statement of actual services." This form should only be used to report services already rendered.
2	Medicaid Claim or EPSDT	Required	Place an "X" in the "Medicaid Claim" box.
2	Prior Authorization #	Conditional	Required if a resubmission. Enter an "A" to adjust or a "V" to void. Also include the original claim reference #.
3 - 7	Carrier Name - Zip	Not required	
8	Patient Name	Required	Enter the last name, first name, & middle initial as it appears on the Medicaid ID card or coupon. Do not use nicknames.
9 - 11	Address, City, State	Not required	
12	Date of Birth	Required	Month, date & year of patient's birth. It must match DOB stated on Medicaid ID card.
13	Patient ID #	Required	Recipient's 10-digit Medicaid ID card. Do not use the check digit.
14	Sex	Required	Place an "X" in the appropriate box.
15 - 30	Phone # - Signature	Not required	
31	Is Patient Covered by Another Plan?	Required	Place an "X" in the appropriate box. If yes, attach EOB from TPL.
32	Policy #	Conditional	If patient is covered by another policy then enter policy #.
33	Other Subscriber's Name	Conditional	If patient is covered by another policy then enter policy holder's name.
34 - 35	Date of Birth - Sex	Not required	
36	Plan/Program Name	Conditional	If patient is covered by another policy then enter the policy name.
37 - 41		Not required	
42	Name of Billing Dentist or Dental Entity	Required	Enter the provider's full name & degree.
43	Phone #	Not required	
44	Provider ID #	Required	Enter 8-digit provider ID # (6-base digits & 2-digit location code separated by a dash.)
45	Dentist SSN or TIN	Required	Dentist's Social Security # or Tax ID #. Must use information used on enrollment form.
46	Address	Not required	
47	Dentist License #	Conditional	Required for referrals only, enter referring provider's 8-digit Medicaid Provider ID #.
48	First visit of date of current service	Not required	
49	Place of treatment	Required	Place an "X" in the appropriate box.
50 - 52	City, State, Zip Code	Not required	
53	Radiographs or model enclosed?	Optional	Place an "X" in the appropriate box. This information helps to verify x-ray attachments.
54	Is the treatment for orthodontics?	Required	Place an "X" in the appropriate box.
55	If prosthesis	Not required	

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56	Is treatment plan result of occupational illness or injury?	Required	Place an "X" in the appropriate box. Enter brief description & dates. Enter the month, date, & year when services are related to occupational illness or injury. If exact date is not known, enter the approximate date.
57	Is treatment result of accident?	Required	Enter the accident month, day, and year when services, if services are related to accidental injury. If the exact date is not known, enter the approximate date.
58	Diagnosis Code Index	Conditional	Used for adult emergency cases only. ICD-9-CM diagnosis code, 525.9, is used to indicate the services are for an adult emergency service.
59	Examination & Treatment Plan	Required	Date: Enter completion date for each service rendered.
	Tooth	Conditional	Used when performing procedures on specific teeth. Identify the tooth using 2-digit numeric characters for permanent teeth & a single-digit alpha character for primary teeth.
	Surface	Conditional	When applicable, identify the proper tooth surface. Up to 4 different tooth surfaces may be indicated.
	Diagnosis Index #	Conditional	Used for adult emergency cases only. Enter a "1" for each line item that is connected to the adult emergency.
	Procedure Code	Required	Enter the appropriate CDT-3 or CDT-4 dental procedure code & modifier.
	Quantity	Required	Enter the # of services or visits for each procedure.
	Description	Required	Provide a narrative description of the services, including materials used.
	Fee	Required	Enter the total charge for each procedure.
	Total Fee	Required	Enter total fees.
	Payment by other plan – Patient pays	Not required	
60	Identify all missing teeth with an "X"	Not required	
61	Remarks for usual services	Conditional	If TPL does not cover the service, TPL may be bypassed by indicating, "Not a covered service."
62	Claim Certification	Required	Signature must be legal names. Must match authorized signature on file with provider application. May use rubber stamp of authorized signature, but it must be initialed by person authorized to sign for provider. Must include license # and date.
63	Address where treatment performed	Not required	
64 - 66	City, State, Zip	Not required	